

REQUEST FOR PRESCRIPTION COST ESTIMATE FOR HIGH DEDUCTIBLE HEALTH PLAN

HOW THE HIGH DEDUCTIBLE HEALTH PLAN PRESCRIPTION COVERAGE WORKS

- Member pays eligible Rx expenses at pharmacy
 - Charges apply to Deductible until satisfied – see Example List on right
 - Deductible Amounts: \$1800 Single / \$3600 family of 2 or more
 - After deductible is met 25% coinsurance is paid
 - 25% continues until plan year out of pocket maximum is satisfied
- Note: If deductible had been satisfied, the member would be responsible for 25% of the billed amount at the pharmacy.*

Drug Name – Example List	Billed
ASMANEX 120 AER 220MCG	\$609.56
LEVOTHYROXIN TAB 75MCG	\$30.00
LOSARTAN POT TAB 50MG	\$21.39
METFORMIN TAB 500MG	\$10.86
METOPROL TAR TAB 50MG	\$22.05
PREDNISONE TAB 10MG	\$9.80
PROAIR HFA AER	\$54.05
TRAZODONE TAB 50MG	\$23.28
All would apply to Deductible	\$780.99

I hereby authorize DAKOTACARE Administrative Services to release prescription cost information from 7/1/16-present for the following individuals* (Last Column is DAS use only)

Member Name	Member ID	Date of Birth	DAS USE ONLY HOF

The listing returned will show the billed price of each drug. Please note this is the amount that will be applied to the deductible/coinsurance on the High Deductible health plan. Drug prices are subject to change.

REFER TO THE PREVENTIVE FORMULARY TO SEE IF YOUR MEDICATION QUALIFIES FOR ZERO COST SHARE

benefits.sd.gov/forms

Member request return information via: ☐ Email ☐ Mail

*Prescription information for any dependent over the age of 18 will not be released to requester via email without the proper HIPAA release. If no release is on file the information will be mailed to the dependent.

Email Address: _____

Mailing Address: _____

X

Signature of Person Making Request

Date

Print Name

Daytime Contact Phone #